STATE OF IDAHO
DEPARTMENT OF INSURANCE
700 WEST STATE STREET, 3rd FLOOR
PO BOX 83720
BOISE, ID 83720-0043

	0560
	1025
FOR DEPARTMENT USE ONLY	1315-10
	TOTAL

STATEMENT OF PREMIUM TAXES AND FEES

PROPERTY AND CASUALTY COMPANIES

C/A NO.	NAIC NO.

COMPANY NAME	FOR CALENDAR YEAR ENDING DECEMBER 31, 2005
MAILING ADDRESS	DOMICILE STATE

RECAP OF TAXES AND FEES

1. TOTAL TAXES DUE (Page 5, Schedule E, Line 5, GREATER of Column A or Column B) $_____

2. LESS TOTAL PREMIUM TAX CREDITS (Page 4, Schedule D, Line 4) $_____

3. LESS 2005 PREPAYMENTS REMITTED: (1) JUNE 15 $_____
   (2) SEPT. 15 $_____
   (3) DEC. 15 $_____ $_____

4. TAX SUBTOTAL - Line 1 less Lines 2 and 3. If negative amount, also enter on Line 8. $_____

5. ANNUAL CONTINUATION FEE for Calendar Year 2006
   MUST ATTACH ANNUAL STATEMENT PAGE 3, LINE 35 is used to determine fee amount.

Surplus less than $10,000,000	$1,000.00
Surplus greater than $10,000,000 but less than $100,000,000	$2,500.00
Surplus greater than $100,000,000	$4,500.00

   $_____

   Payment of continuation fee must be included.
   Do not use overpayment of tax on Line 4.

6. PLUS PENALTY, IF DUE ($25.00 per day from postmark delinquency. Idaho Code § 41-404) $_____

7. AMOUNT ENCLOSED – ADD Lines 5 and 6. Include Line 4 if not a negative amount.
   Make check payable to: **Idaho Department of Insurance.**
   There will be a $20.00 charge on all returned checks. Idaho Code § 28-22-105
   Your canceled check is your receipt. $_____

   Indicate if payment is by EFT _____

8. REFUND DUE FOR TAX OVERPAYMENT ONLY $_____

Under penalty of perjury, I declare that this statement (including any accompanying schedules and statements) has been examined by me and to the best of my knowledge and belief is a true, correct, and complete statement.

Contact Person

( )
Telephone Number Ext.

Signature of Officer Date

Name and Title (Type or Print)

SCHEDULE A - COMPUTATION OF PREMIUM TAX - PROPERTY AND CASUALTY (P/C) (EXCLUDING ACCIDENT AND HEALTH)

1. TOTAL DIRECT PREMIUMS WRITTEN PLUS SERVICE OR FINANCE CHARGES (including policy, membership, installment and similar fees), LESS RETURN PREMIUMS ON POLICIES NOT TAKEN. This amount must agree with the ATTACHED Annual Statement Schedule T and Idaho Business Page, excluding accident and health direct premiums. $_____

2. IDAHO DOMESTIC INSURERS - Enter total premiums minus dividends from attached SUPPLEMENT 1 - Business in Jurisdictions not Licensed. $_____

3. LESS DIVIDENDS PAID OR CREDITED TO THE ACCOUNT OF POLICYHOLDERS. Must agree with ATTACHED Annual Statement Idaho Business Page and Schedule T, excluding accident and health dividends. $_____

4. PREMIUMS EXEMPT AND/OR PREEMPTED BY FEDERAL LAW:

TYPE OF PREEMPTION/EXEMPTION	PREMIUMS
A. Multiple Peril Crop	$_____
B. Federal Flood	$_____
C._____	$_____

TOTAL EXEMPT PREMIUMS (Add Lines 4A through 4C) $_____

5. NET TAXABLE PROPERTY AND CASUALTY PREMIUMS (Line 1 + Line 2 - Line 3 - Line 4) $_____
Carry forward to Page 5, Schedule E, Line 1, Column A.

6. PREMIUM TAX - 2.5% (1.4%) of Line 5. (Report negative amounts.)
Carry forward to Page 5, Schedule E, Line 1B, Column A.
If qualified for the 1.4% reduced tax rate under Idaho Code § 41-403, you must complete and attach Page 6 and 7, Schedule F. $_____

RETALIATORY SCHEDULE E MUST BE COMPLETED.

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7. **DIRECT PREMIUMS WRITTEN FOR PURCHASING GROUPS included on Line 1**
Must agree with ATTACHED Schedule T, Line 13, Column 9 and with the Premium Volume Reports submitted by all individual Purchasing Groups $_____

To verify Annual Statement purchasing group premiums, enter your company's

_____Direct Telephone_____ Ext._____
Purchasing Group Contact Person

⇔ **COPIES OF THE ANNUAL STATEMENT SCHEDULE T AND IDAHO BUSINESS PAGE MUST BE INCLUDED FOR VERIFICATION.**

SCHEDULE B - COMPUTATION OF PREMIUM TAX - ACCIDENT AND HEALTH

1. TOTAL DIRECT PREMIUMS WRITTEN (including policy, membership, installment and similar fees), LESS RETURN PREMIUMS ON POLICIES NOT TAKEN.
   This amount must agree with the ATTACHED Annual Statement Idaho Business Page, Column 1. $_____

2. IDAHO DOMESTIC INSURERS - Enter total premiums minus dividends from attached SUPPLEMENT 2 - Accident and Health Business in Jurisdictions not Licensed. $_____

3. LESS DIVIDENDS PAID OR CREDITED TO THE ACCOUNT OF POLICYHOLDERS.
   This amount must agree with ATTACHED Annual Statement Idaho Business Page, Column 3. $_____

4. PREMIUMS EXEMPT AND/OR PREEMPTED BY FEDERAL LAW:

TYPE OF PREEMPTION/EXEMPTION	PREMIUMS
A. Federal Employers Health Care	$_____
B. _____	$_____
C. _____	$_____

TOTAL EXEMPT PREMIUMS (Add Lines 4A through 4C) $_____

5. NET TAXABLE ACCIDENT AND HEALTH PREMIUMS (Line 1 + Line 2 - Line 3 - Line 4) $_____
   Carry forward to Page 5, Schedule E, Line 2, Column A.

6. PREMIUM TAX - 2.5% (1.4%) of Line 5 (Report negative amounts.)
   Carry forward to Page 5, Schedule E, Line 2B, Column A.
   If qualified for the 1.4% reduced tax rate under Idaho Code § 41-403,
   you must complete and attach Pages 6 and 7, Schedule F. **$**_____

RETALIATORY SCHEDULE E MUST BE COMPLETED.

⇔ **COPIES OF THE ANNUAL STATEMENT SCHEDULE T AND IDAHO BUSINESS PAGE MUST BE INCLUDED FOR VERIFICATION.**

NAME OF ADMINISTERED PLAN**:** _____

ADDRESS: _____ CITY: _____

NAME OF CONTACT PERSON**:** _____

SCHEDULE C – EACH INDIVIDUAL SELF FUNDED PLANS

NUMBER OF BENEFICIARIES COVERED PER MONTH: Idaho Code § 41-4012

JANUARY	_____	JULY	_____
FEBRUARY	_____	AUGUST	_____
MARCH	_____	SEPTEMBER	_____
APRIL	_____	OCTOBER	_____
MAY	_____	NOVEMBER	_____
JUNE	_____	DECEMBER	_____

TOTAL BENEFICIARIES _____

X $.04 =

TOTAL TAX DUE $_____

ADD each to total reported on Page 5, Column A, Line 4 – OTHER TAXES

SCHEDULE D - TAX CREDITS

IN ORDER TO RECEIVE TAX CREDITS, SCHEDULES MUST BE ATTACHED

1 CLASS B CREDITS
IDAHO INSURANCE GUARANTY ASSOCIATION
WESTERN GUARANTY FUND $_____N/A_____

2. CLASS B CREDITS
IDAHO LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION $_____N/A_____

3. WORKERS COMPENSATION TAX CREDITS
(Total from attached Schedule 7, Line 6) $_____

4. TOTAL ALLOWABLE IDAHO CREDITS (Add Lines 1 through 3) **$**_____
Carry Forward to Page 1, Recap of Taxes and Fees, Line 2.

LINE 4 CANNOT EXCEED THE TOTAL PREMIUM TAX LIABILITY
Page 5, Schedule E, Line 5, Column A or B, whichever is greater.

SCHEDULE E - COMPUTATION OF RETALIATORY TAXES

Idaho Code § 41-340 (2) and (3)

NET PREMIUMS SUBJECT TO TAX:	Column A AMOUNT PAID IN IDAHO	Column B AMOUNT WOULD PAY IN DOMICILE STATE
1. PROPERTY AND CASUALTY PREMIUMS	$_____	$_____
A. PREMIUM TAX RATE	2.5% or 1.4%	_____
B. PREMIUM TAX (Line 1 x Line 1A)	$_____	$_____
2. ACCIDENT AND HEALTH PREMIUMS	$_____	$_____
A. PREMIUM TAX RATE	2.5% or 1.4%	_____
B. PREMIUM TAX (Line 2 x Line 2A)	$_____	$_____
3. MUNICIPAL, CITY OR COUNTY PREMIUMS	XXXXXXXXXXXXXXXXXXXX	$_____
A. MUNICIPAL, CITY OR COUNTY TAX RATE	XXXXXXXXXXXXXXXXXXXX	_____
B. MUNICIPAL, CITY, COUNTY TAX (Line 3 x Line 3A)	XXXXXXXXXXXXXXXXXXXX	$_____
4. OTHER TAXES – Identify Each:		
SELF-FUNDED PLANS (Schedule C)	$_____	$_____
_____	XXXXXXXXXXXXXXXXXXXX	$_____
5. TOTAL TAXES (Lines 1B+2B+3B+4) Carry GREATER AMOUNT of Column A or B forward to Page 1, Recap of Taxes, Line 1	$_____	$_____

SCHEDULE F - QUALIFICATION FOR REDUCED PREMIUM TAX

Idaho Code § 41-403

Complete, sign and attach, only if you are requesting the reduced tax rate on Pages 2 or 3.

An itemized schedule must be ATTACHED showing qualified investment descriptions, amounts, types, inception and maturity dates for each Idaho investment; and must agree with amounts reported on Annual Statement, Page 2 as Net Admitted Assets in Column 3.

Reduced Tax Qualification for Year Ending December 31, 2005

Public Obligations	$ _____
Corporate Bonds	$ _____
Preferred Stock	$ _____
Common Stock	$ _____
Mortgage Loans	$ _____
Real Estate	$ _____
Time Deposits	$ _____
Other (Explain)_____	$ _____
TOTAL QUALIFYING IDAHO INVESTMENTS	$ _____
Enter Total Admitted Assets (ATTACHED Annual Statement, Page 2, Line 26, Column 3)	$ _____
Percentage of Qualifying Idaho Investments to Admitted Assets	_____%

NOTE: Qualification for the reduced premium tax rate (1.4% or retaliatory rate, whichever is greater) shall be in strict conformity with the provisions of Idaho Code § 41-403, and the computation for qualification made hereon shall be subject to examination and review by the Department of Insurance.

I hereby certify that the investments listed herein are qualifying Idaho investments as provided by Idaho Code § 41-403, and that the company, as shown above, has qualified at all times throughout the year for the reduced premium tax rate.

_____ Date

_____ Signature

_____ Name and Title (Type or print)

MONTHLY TOTALS REQUIRED FOR QUALIFYING IDAHO INVESTMENTS

	TOTAL ADMITTED ASSETS	TOTAL QUALIFIED IDAHO INVESTMENTS	PERCENTAGE RATIO
Per Annual Statement Prior Year's Balance December 31, 2004	$_____	$_____	_____
January	$_____	$_____	_____
February	$_____	$_____	_____
March	$_____	$_____	_____
April	$_____	$_____	_____
May	$_____	$_____	_____
June	$_____	$_____	_____
July	$_____	$_____	_____
August	$_____	$_____	_____
September	$_____	$_____	_____
October	$_____	$_____	_____
November	$_____	$_____	_____
December 31, 2005	$_____	$_____	_____